November 8, 2004

Re: MDR #: M2-05-0152-01
IRO #: 5055

TRANSMITTED VIA FAX TO:
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Dear ___

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management and Neurology and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- Letters of medically necessity 08/31, 08/10, 07/07, 06/11/2004
- Evaluation 05/27/04

Information provided by Respondent:
- Correspondence
- Independent evaluation/FCE 08/17/04
- Required medical exam 12/30/03

Information provided by Treating Docto:
- Office visits 09/19/03 – 01/16/04
- EMG report 09/02/99
- Radiology report 07/26/99

Information provided by Psychiatrist:
- Office visit 02/22/02

Information provided by Orthopedist:
- Office visit 02/03/04

Information provided by Orthopedist:
- Office visits 09/24/02 – 07/27/04

Clinical History:
This claimant sustained a work-related injury on ___ that resulted in a chronic history of knee pain, which has not been adequately controlled with at least 6 procedures to the knee and other more conservative management such as medications, physical therapy, etc. Psychological co-morbidites such as major depression have been indicated. The claimant has been referred for treatment in a chronic pain program that would focus on psychotherapy, as well as physical rehabilitation and medication adjustment as necessary.

Disputed Services:
Chronic behavioral pain management X 10 sessions.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the pain management program in dispute as stated above is medically necessary in this case.

Rationale:
This claimant has obviously had longstanding pain as a result of the work-related injury along with psychological consequences including depression, anxiety, etc. It is also clear that he has not benefited significantly from the interventions that have been attempted so far, including surgeries, injections, medications, physical therapy, etc. Therefore, it would be reasonable to have this claimant undergo a multidisciplinary chronic pain program in which different modalities may be used to address the different components to this claimant's presentation. Approval for 10 sessions may be reasonable initially to see if any progress can be documented (especially in physical function, as this may be too short a time to expect improvement in emotion or psychological conditions). Certainly, if there is progress, then additional physical/rehabilitative modalities as well as continued psychological pain preventions can be considered either with more sessions in the pain program or through other means.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on November 8, 2004.